

Provider / Insurer Round Table Summit

Objectives:

- Continue the conversation between providers and payers on how to best work together to solve the opioid abuse problem in Utah
- Collaborate to improve pain management and mental health services throughout Utah
- Present prevention strategies and treatment of opioid abuse from subcommittees
- Devise collaborative next steps/action plan

Agenda Overview:

9:00-9:30 a.m.	Welcome / Lived Experience Panel / Subcommittee Accomplishments
9:30 – 11:00 a.m.	Subcommittee (Prevention and Behavioral Health, Pharmacological Treatments, Non-pharmacological Treatments) Discussion / Recommendations
11:00 – 12:30 p.m.	Lunch and Substance Use Disorder Treatment Discussion
12:30 – 1:00 p.m.	Action Items and Adjourn

Detailed Agenda and Discussion Guide

9:00-9:30 a.m.

Welcome – UCO-OP Executive Committee Leadership

Lived Experiences - Parent and Pain Management Patient

Subcommittee Accomplishments – Trish Barrus, Provider Training and Patient Education
Co-chair

9:30-11:00 a.m.

Prevention and Behavioral Health Subcommittee - Dave Wilde

Discussion: In the latest report by the CDC, Evidence-Based Strategies for Prevention Opioid Overdose: What’s working in the United States, 2018, it is suggested that when treating patients the guiding principle should be “meeting people where they are” which means *more than showing compassion or tolerance to people in crisis. This principle also asks us to acknowledge that all people we meet are at different stages of behavior change. Furthermore, recognition of these stages helps us set reasonable expectations for that encounter.*

The report cites the Transtheoretical model of Behavior Change (Prochaska and Clemente) which outlines how behavior change often occurs. The model emphasizes the need to understand the experience of the person practitioners are trying to reach in order to help them. To promote change, interventions must be provided that are appropriate for the stage the patient is in (CDC report pg. 4).

How can practitioners know this without proper assessment?
How can we best implement the proposals made by the committee on SBIRT and Behavioral Health issues?

Recommendations:

1. Increase Academic detailing regarding SBIRT.
 - a. Improve SBIRT knowledge about screening, implementation, referral to treatment and billing.
 - b. Increase awareness for providers and healthcare systems about open SBIRT codes and what situations SBIRT code is reimbursed vs. bundled.
 - c. Improve and increase SBIRT marketing
2. Identify gaps in mental health parity for pain and addiction treatment. Mental health and comprehensive assessment needs to be a part of the pain management treatment plan.
3. Work together with Insurance representatives to:
 - a. create a list of objective measures for mental health specialists to prove specialization in addiction and/or pain treatment to assist insurance paneling and help healthcare systems identify qualified MH providers.
 - X hours/CEU of addiction medicine training?
 - X hours/CEU of pain treatment training?
 - b. to provide training programs with information on integrated health care and pain management, and
 - c. to increase reimbursement for SBIRT codes and not bundle these codes with other E&M codes

Pharmacological Treatment Subcommittee – Bridget Shears

Discussion: As a patient and provider determine that tapering their opioid medication would be in the patient's best interest, barriers related to payer coverage result in delays in treatment.

Background: Opioid tapering is the methodical reduction in the opioid dosage and daily morphine milliequivalent consumption. The process involves frequent medication and dosage changes, including occasional stepping from one controlled substance schedule to another. The rate or speed of tapering is also a consideration and is based on the urgency of risk for the patient remaining at their starting opioid dosage or the need for tapering i.e. upcoming surgery or pregnancy. Tapering rate can be slowed or increased based on patient tolerance. The recommended start of an opioid taper plan is a 10% dose

reduction per week. When possible, the patient is instructed to cut the pills they are currently taking to achieve the lower dose without the need for a new prescription. However, if the tapering process requires a change to another less potent opioid, the patient will need a new prescription and possibly one in a different controlled substance schedule. Occasionally during some tapering processes, the addition of a short acting opioid may also be prescribed to manage breakthrough pain. Frequent monitoring and adjustments to the treatment plan are required during this methodical process.

Assessment: When the transition from one opioid to another results in a new prescription, the patient is faced with prior authorizations for the new drug, particularly when the change occurs within a 30 day period from the previous prescription. In cases of a transition from one controlled substance schedule to another, a denial may occur resulting in the need for an appeal and delays in the patient treatment plan.

Recommendation: For patients undergoing an active opioid tapering treatment plan, a process should be developed to bypass the pre-authorization when transitioning from one opioid to another and particularly no denials should occur when a patient is moving from one drug schedule to another. The medical provider should present the payer provider with documentation of the opioid taper treatment plan with an expected timeline or schedule for the duration of the taper. If a change in the treatment plan needed, the revised plan should be shared with the payer provider.

Non-Pharmacological Treatment Committee - Michael Giovanniello, M.D. and Christopher Duncan DC

Background: The Utah Coalition for Opioid Overdose Prevention brought us together to collaborate on the public health crisis of opioid misuse, abuse, and addiction. This has been labeled “the Opioid epidemic”. Although this is true, as providers we recognize this stems from a chronic pain management crisis. Practitioners want to focus on non-pharmacologic management options for treatment of chronic pain patients with a goal of opioid sparing.

Current guidelines^{1, 2, 3,4,5,6,7} and research^{8,9} recommend non-pharmacologic treatments and non-narcotics (e.g., NSAIDs) as first line treatment(s) for the management for pain. By contrast, opioids are virtually never primary treatments.^{10 11 12} Implementing evidence-based use of these preferred non-pharmacological pain treatments, along with other steps being taken by providers and payers in our community, should markedly reduce the need for opioid prescriptions.

Recommendations: The Non-pharmacological Treatment Committee recommends the following:

1. Evidence-based non-pharmacological treatments be utilized in a comprehensive/integrative treatment strategy,
2. Continue collaboration with providers, payers, and legislators to advocate for policy initiatives that remedy the system and reimbursement barriers to evidence-informed comprehensive pain care,
3. Establish education opportunities to train healthcare providers and administrators in the evidence base of effective non-pharmacologic practice, and
4. Promote ongoing research to establish the role of effective non-pharmacologic treatments for pain.

Following through with these recommendations will allow providers the opportunity to establish the goal of avoiding and/or reducing the use of opioid medications.^{13, 14, 15} The following non-pharmacologic treatment options, in the construct of an integrative pain management model, need to be established.

- Mental health i.e. Cognitive behavioral therapy, Fear avoidance, Acceptance therapy, and Mindfulness therapies
- Spinal Manipulation
- Exercise therapy (especially focusing on aerobic and strengthening)
- Movement therapies such as Tai Chi and Yoga
- Acupuncture
- Massage
- Procedural Interventions
- Physical/Occupational Therapy
- Functional Restoration

The American College of Physicians(ACP), US Department of Health and Human Services National Pain Strategy, and other organizations have developed evidence based guidelines that are consistent with these non-pharmacologic therapies as first line treatment options.

Note that which treatment is effective for which disorder is beyond the scope of this document, but is naturally of critical importance to effect the best outcomes.

Barriers:

1. Lack of knowledge of what is efficacious for what disorder highlighted by, Inadequate training in evidence-based systematic, sequential, and hierarchical approaches to managing acute, subacute, peri-operative, and chronic pain
2. Time to diagnose, prescribe, and teach most of these options is considerably longer than to prescribe an opioid, (SBIRT and pre-authorizations) and are often not reimbursed commensurately
3. Medicalizing cases, including widespread propensities to add additional treatment without removing unsuccessful ones (medical/non-medical) and failure to get an accurate initial diagnosis (treating depression and anxiety with opioids).
4. Insufficient financial and systems' resources and support to implement these treatments and procedures
5. Out of pocket costs due to limited reimbursements and multiple co-pays for a single treatment plan
6. Patient reluctance to engage in active exercises and to devote time to their problem(s)
7. Inadequate collaboration/communication between providers
8. Lack of access in rural communities

Working together as a committee we have acknowledged that these barriers fall into two categories - financial barriers and education . These barriers are real and must be overcome in order to use non-pharmacological treatments to promote opioid sparing. To overcome these barriers requires thoroughly addressing education of all 3+ parties (patient, provider, and payor). Educational efforts must include evidence-based approaches that are sequential and hierarchical, e.g., when to use which treatment for what disorder and what to do when initial approaches fail. This also requires better integration of clinicians who perform these services into delivery systems (e.g., chiropractic physicians, physical therapists, occupational therapists, mental health providers, massage therapists, acupuncturists) and frequent communications between and among those managing a given patient's care. This will also require addressing reimbursement policies, insurance networks and out of pocket costs.

Recommendation 1: We recommend the creation of education modules leading to a certification to address the education need highlighted by the UCO-OP survey results.

We anticipate that these trainings would be voluntary, modular, multi-modal, primarily distance-based, free, and include self-assessments to allow offering of continuing education credits. Ideally, modules would be developed for the most common disorders (e.g., Low Back Pain) to address different Healthcare Professionals needs and emphasize the first line treatment recommendations. It is anticipated that the most common disorders would be addressed first. To optimize costs, peer-reviewed, evidence-based guidelines would likely form the basis for these training modules. A generic approach module would likely be needed to address primary care providers who may not offer the non-

pharmacological treatments in house. This curriculum should be approved and certified by professional associations or the Department of Health.

In order to build a collaborative network and create a common language in which all types of providers can communicate, it is essential that both medical and non-medical providers who seek to provide chronic pain care receive this training. This training should be incentivized in order to maximize its effect. The UMA already provides similar training. We recommend that the UMA participate in this process updating their mandated opioid prescriber training module as needed.

Discussion:

- Recommendation of committee
- More specific diagnosis is critical to avoid treating psychological diagnosis with opioids
- The need to perform a comprehensive exam with behavioral screening/stratification
- What is a complete pain management visit?

Recommendation 2: We recommend that insurance payers make the following efforts to improve accessibility and coverage of the effective evidence based non-pharmacological treatments recommended by the guidelines previously cited.

Financial elements of a population-based approach to improve implementation of evidence-based medical treatments and thereby reduce opioids prescriptions need to be addressed. These elements include:

1. incentivization of training,
2. removing financial barriers to implement evidence-based treatments,
3. access to treatments currently precluded from reimbursement by adding these treatments to the essential health benefits list,
4. network availability,
5. using financial incentives that favor the use of nonpharmacologic options over opioids,
6. appropriate safeguards to reduce medicalization and needless waste.

There is consideration for how training could be incentivized in order to maximize its impacts. One option could include incentivization for insurance companies to include trained and/or certified providers into a preferred provider program where patients have a lower copay or coinsurance for utilizing a trained/certified provider, and trained/certified providers would be given better/easier reimbursements for these cases.

Making these recommended treatments essential health benefits is a first step, but without the proper resources such as network availability any mandate is effectively useless. Precedent has been established through legislation in other

states and through the passage of the Comprehensive Addiction Recovery Act (2016). These initiatives establish the need for interdisciplinary pain care teams, behavioral therapy, Physical Medicine and Rehabilitation, addiction therapy, as well as expansion of complimentary and integrative health services. The solution for Utah will need continued guidance on the most effective implementation across such broad and diverse platforms with the resources that are available. In order to create a collaborative benefit design that pairs current available resources with these recommended treatment options, it is recommended that the UCO-OP Executive Committee or another state-wide entity oversee recommending policy changes as needed and recommending any legislative changes directly to the legislature through the governor's office.

Discussion:

- How can this Recommendation be implemented? Who are the accountability partners?
- Reduce burden of preauthorization to facilitate efficient and effective management in a timely fashion

The removal of prior authorization requirements allows a patient to be initiated onto treatment the same day they see their doctor. This immediate initiation reduces the patient's risk of overdose in the subsequent days and increases the likelihood that they will successfully engage in and remain connected to treatment. (CDC Report, 2018)

- Reduction of multiple copays for same day service
- Out of pocket costs
- Reimbursement commensurate with complexity
- How to reduce abuse of over utilization

Recommendation 3: We recommend amending the “Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain” to include the list of recommended non-pharmacological alternatives.

Understanding that this document is about how to safely prescribe opioids there is good reason for not including more information regarding other recommended treatments, however creating a separate document will diminish the effectiveness of reaching providers who prescribe opioids. The number one complaint of providers in the state who prescribe opioids is that they are unaware of the options for pain other than opioids. We feel that emphasizing the most effective integrated treatment options in this document will help to reduce opioid prescribing by presenting treatment options to those most likely to prescribe opioids. We recommend the following treatments be added to the guidelines: Mental health i.e. Cognitive behavioral therapy, Spinal Manipulation, Fear avoidance, Acceptance therapy, and Mindfulness therapies, Exercise therapy (especially

focusing on aerobic and strengthening), Movement therapies such as Tai Chi and Yoga, Acupuncture, Massage, and Procedural Interventions.

Discussion:

- Recommendation
- Creating a new system of care for pain. Evidence finds integrated teams to be most effective and cost effective for the treatment of pain.
- Address the underlying problem of chronic pain management, not just restricting access to opioids
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- Discuss/collaborate with health care plans the need to offer diverse pain management options
- Next steps

11:00-12:30 p.m.

Lunch and Substance Use Disorder Treatment Discussion

Some conditions require multiple attempts at treatment or long term care. For example, patients may require rehabilitation programs multiple times. Chronic pain may be managed by physical modalities rather than opioids but may require significantly more visits than most insurances allow.

Does your insurance company cover rehabilitation programs or chronic pain management, and recognize through coverage that the patient may need these service more than may be currently covered?

1. Does your insurance company help to educate patients about best practices with MAT if they have an opioid use disorder? What is your policy regarding coverage of suboxone vs. vivitrol?
2. Are the payers promoting short rehabilitation treatment center stays over longer, less intensive treatment? What is your insurance company's rationale for utilizing one over the other? Does your company provide adequate information to assist the patient with making an informed decision if the patient is part of the decision-making process?
3. Do more guidelines need to be in place and outcome studies be required of treatment centers? How do insurances decide what recovery centers they will reimburse for treatment?

12:30-1:00 p.m.

Action Items and Adjourn